The Health of New Hampshire's Community Hospital System

A Financial Analysis

Mary Hitchcock Memorial Hospital




Office of Planning and Research
New Hampshire Department of Health and Human Services
129 Pleasant Street • Concord, New Hampshire 03301
www.dhhs.state.nh.us

An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

February 2001

Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

Acknowledgements

The Department wishes to thank the following individuals and organizations for making this financial analysis possible. First, this project was made possible through a grant from The Robert Wood Johnson Foundation's *Access Project*, directed by Catherine Dunham, Ed.D. Second, Dr. Nancy Kane and her graduate students at the Harvard School of Public Health prepared the financial analysis and narratives. Finally, the Department extends its appreciation to the Chief Financial Officers and Presidents of each New Hampshire hospital for reviewing the standardized financial spreadsheets and financial analysis to ensure their accuracy.

For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MARY HITCHCOCK MEMORIAL HOSPITAL
LEBANON, NEW HAMPSHIRE
1993 – 1999 FINANCIAL ANALYSIS

Mary Hitchcock Memorial Hospital is a 343-bed, acute-care teaching hospital in Grafton county[3]. As of 1997, private insurers followed by Medicare represented the largest percentage of payers for inpatient discharges (47% and 35%, respectively)[4].

The Hitchcock Alliance, formed in 1983, is the not-for-profit (NP) holding company of the hospital. The hospital has two wholly owned subsidiaries: Hitchcock Imaging Services, Inc. (NP), which was consolidated with the hospital but became inactive after 1996, and MHMH Enterprises, Inc., a for-profit subsidiary that holds investments in real estate and in a partnership that provides home health services. MHMH Enterprises is accounted for by the equity method. Additionally, the hospital is a member of the Dartmouth-Hitchcock Medical Center (NP). In 1993, the hospital assumed legal and financial responsibility for the Lebanon practice site of the Hitchcock Clinic, a nonprofit corporation operating multispecialty group clinics throughout New Hampshire and Vermont. In 1997, the hospital and the Hitchcock Clinic signed a joint operating agreement.

As a member of this system, the hospital is affiliated with Upper Connecticut Valley Hospital and Weeks Hospital Association.

Summary of Financial Analysis 1993-98
Over the six-year period, total profit margins were consistently in the range of 4-6%, with spikes in 1994 (8%) and 1997 (11%). Operating margins were in the 1-3% range except for a 5% margin in 1995. After meeting operating cash requirements, the hospital generated $271M in cash over the period, 70% of which was used to increase marketable securities. This investing strategy produced a large amount of liquidity – 464 days of unrestricted cash on hand as of 1998 - and generated substantial investment income. The hospital has reduced its reliance on long-term borrowing over the period, such that its equity financing ratio is up to 49% in 1998, with strong debt service coverage of 2.99 from operating services alone.

Cash Flow Analysis 1993-98
The hospital generated cash internally, mostly from depreciation (43%), net income (31%), and selling noncurrent assets (12%). Improved management of working capital, namely improved collections from patient accounts receivable, generated an additional 10% of the total cash over the period.

The hospital used cash predominantly to invest in cash and marketable securities, doubling its current and Board designated discretionary cash reserves over the period. This investment in marketable securities represented more than three times the level of investment in property, plant and equipment (70 versus 22%, respectively). Though investment in property, plant, and equipment (PP&E) ($58M) was 41% less than depreciation expense ($99M) over the period, it appears to be adequate given the very young age of plant (around 2 years) at the beginning of our period of analysis (1992). The 1998 age of 7 years is below the state average.

[3] The 1998 American Hospital Association Guide.
[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

Affiliate transactions absorbed $18M (7% of total cash) over the period, and reduced its long-term liabilities by $4.8M.

Ratio Analysis 1993-98[5]

Profitability

Profitability was driven by nonoperating revenues, mainly investment income, which reflects the hospital's investing strategy. Nonoperating revenues consistently contributed over two-thirds of the bottom line, with the exception the hospital's most profitable year in 1997, when realized gains on the sale of investments drove the nonoperating contribution to almost 80%. In fact, realized gains alone comprised two-thirds of the bottom line in this year.

In 1994, the high profit margin was driven by an improved operating income, which resulted from a decrease in deductions from revenue for payer discounts and contractuals. (The decrease was due to a $8 million Medicare settlement due to geographic re-classification.) The operating margin thinned after 1994 due to slowed growth in the markup relative to the deductible, remaining at 2-3% until 1998. Markups remain below the state median over the period of analysis.

Liquidity

The hospital has a strong cash position, though overall liquidity trends are not favorable. Over the six-year period, the current ratio steadily declined, and by 1998 indicated that the hospital barely had enough current resources to meet its short-term obligations. With the inclusion of unrestricted marketable securities (board-designated asset category), however, this measure reveals that the hospital can meet its current liabilities easily.

Despite the drop in short-term sources of cash to 15.6 days in 1998, the hospital built a large amount of discretionary cash over the period – 464 days of unrestricted cash on hand as of 1998 – as a result of its investment strategy. Board-designated investments, totalling $269M, exceed total long term debt of $178M, leaving over $90 M in discretionary cash beyond the total amount owed (which is well covered at this point by operating cash flows). (Note: Growth in this measure between 1996 and 1997 may be inflated due to an accounting principle change requiring certain investments to be stated at market value rather than cost).

A decrease in days in accounts receivable contributed to the accumulation of cash since 1995; however, this measure rises to over 60 days in 1998. The growth in average pay period between 1996 and 1997 indicates that slowed payments to vendors may also have contributed to the large growth in cash in 1997.

Capital Structure

The equity financing ratio illustrates that the hospital is relatively leveraged compared with other hospitals in the state. This ratio demonstrates that more than half of the hospital's total assets are financed with debt, which is relatively highly leveraged for hospitals in New Hampshire (most of which are quite a bit smaller).

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

The debt service coverage indicates that the hospital generates enough cash from yearly income to cover its debt principal and interest payments easily, even when only operating income is considered. Cash generated from net income generally covered only 12% of the total debt, while cash from operating income alone only covered 8% as of 1998, which is getting toward the low end of coverage, indicating some heightened risk.

Charity Care and Community Benefits

Charity care reported as charges forgone generally represented approximately 3% of gross patient revenues from 1993 to 1997, though this dropped to 2% in 1998. This amount of charity care meets the estimated value of the hospital's tax exemption when 50% of bad debt is added. In 1997, the hospital's most profitable year, charity care met the hospital's estimated tax benefit when 100% bad debt was included.

In addition to charity care, footnotes to the financial statements cited numerous activities as charitable, such as Medicare costs exceeding payment, emergency room access 24 hours a day, and staff's involvement in volunteer activities/community organizations and its own volunteer program. Mary Hitchcock Memorial Hospital is also a major teaching hospital in the state.

Additionally, the hospital offers HIV/AIDS services, a neonatal intensive care unit and a trauma center[1], which may also be considered an additional charitable benefit to the community.

Cash Flow Analysis 1993 – 1999

Trends in the sources and uses of cash for this period are similar to the 1993 - 1998 analysis. The hospital has generated the majority of its cash from non-cash expenses (44%), followed by net income (36%). 11% has been generated in the decrease of non-current assets.

Mary Hitchcock has used cash primarily to invest in board-designated funds (66%). Less than half of this amount (24%) has been used to purchase property, plant, and equipment (PP&E). Although the investment in property, plant and equipment (PP&E) was 45% less than depreciation expense, the average age of plant is still relatively low at 7.48 years.

1999 Ratio Analysis

Profitability

Mary Hitchcock shows a total margin of 9% and an operating margin of 2%. In 1999, expenses and revenues grew at the same rate of 9%. Investment income doubled to $20M in 1999.

Liquidity

The hospital is able to meet its current liabilities with its current resources (current ratio: 5.63). Mary Hitchcock also has 456.74 days cash on hand, including board-designated funds, a slight decrease from 463.99 days in 1998. This indicates strong liquidity. The hospital's 65.5 days in accounts receivable is an increase from 64.03 days in 1998—slightly below the average for New Hampshire and just over the national average. Its average payment period of 61.28 days is a decrease from 62.07 days in 1998. Although this is well above the state average, the payment period is improving, and it has not adversely affected the hospital's financial situation.

Capital Structure

Mary Hitchcock shows a long-term debt to equity ratio of 0.60, which is a decrease from 0.75 in 1998. This favorable change indicates that the hospital is less risky as far as capital structure is concerned. The hospital generates enough income to cover its debt service (debt service coverage ratio: 5.81), even when considering only operating income (3.23). Overall, the hospital's solvency is very good.

Charity Care and Community Benefits

In 1999, charity care reported as charges forgone represented 2.10% of gross patient service revenue. This is up from last year's 1.92%. Additionally, bad debt represents 2.24% of the GPSR. This is slightly lower than the 2.45% from 1998. The hospital supports a number of programs including the Children's Hospital at Dartmouth, the Norris Cotton Cancer Center, and the Dartmouth Hitchcock air response team. It also dedicates resources to a variety of community service organizations including the New Hampshire Poison Information Center, the Women's Health Resource Center, several free clinics, and health education programs.

Summary

With above average profitability, strong liquidity, and very good solvency, Mary Hitchcock is in excellent financial shape.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health